

State Form 8200 (R3/08-00) Indiana State Department of Health-Division of Long Term Ca

| (| Care | | | | | |
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| | DIVISION OF LONG TERM CARE | | | | | |
| | Date Received Date Approved Approved by | | | | | |
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| YPE OF APPLICATON | | | | | | |
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Please Print or Type SECTION I - T Application (check appropriate item) ☐ New Facility ☐ Other ☐ Change of Ownership (Anticipated date of Sale/Purchase/Lease)_ **SECTION II - IDENTIFYING INFORMATION** A. Practice Location (facility) Name of Facility Street Address P.O. Box: City Zip Code +4 County Telephone Number Fax Number Facility's Cost Reporting Year To (mm/dd): From (mm/dd): B. Licensee/Ownership Information Licensee (Operator(s) of the facility) The licensee and the applicant entity as described in Item IV-A of this application should be the same. P.O. Box Street Address City State Zip Code+4 Telephone Number Fax Number **EIN Number** Fiscal Year End Date (mm/dd) C. Building Information 1. Status of building to be used (check appropriate item) ☐ Proposed New Construction ☐ Alteration of Existing Building ☐ Existing Licensed Health Facility ☐ Other_ Type of Construction (materials) (if new, as certified by architect or engineer registered in the state of Indiana) D. Type of Services to be Provided **Level of Care** Number of Beds 2. Certification Designation Number of Beds in Each Category in Each Category (to be licensed) (to be licensed) Residential ☐ SNF (Title 18 – Medicare) SNF/NF (Title 18 – Medicare/Title 19 – Medicaid) ☐ Comprehensive (Certified) ☐ Comprehensive (Non-certified) ☐ NF (Title 19 – Medicaid) ☐ ICF/MR ☐ Children's Facility ☐ Developmentally Disabled **Total Number of Licensed Beds Total Certified Beds**

| SECTION III – STAFFING | | | | | | |
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| A. Administrator | | | | | | |
| Name (enter full name) | | | | | | |
| Indiana L | icense Number (please include a copy of license wi | th application) | Date of | Birth | Date employed in this position | |
| 1. | List post secondary education and health related e | xperience | | | | |
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| 2. | On a separate sheet, list the facilities in Indiana, or any other state, in which the Administrator has been previously employed, including the dates of employment and reason for leaving. Identify on this list any of these facilities which were operating with less than a full license at the time the Administrator was employed. | | | | | |
| 3. | Has the administrator ever been convicted of any criminal offense related to a dependent population? Yes No (If yes, state on a separate sheet the facts of each case completely and concisely) | | | | | |
| 4. | Has the administrator's license ever lapsed, been suspended or revoked? \Box Yes \Box No (If yes, state on a separate sheet the facts of each case completely and concisely) | | | | | |
| 5. | Is the administrator presently in good health and physically able to fully carry out all of the duties in the operation of this health facility? Yes No (If no, explain on a separate sheet) | | | | | |
| | ctor of Nursing | | | | | |
| Name (ei | nter full name) | | | | | |
| Indiana L | icense Number (please include a copy of license wi | th application) | Date of birth | | Date employed in this position | |
| Education | n (Name of School of Nursing) | | | | | |
| School Degree Year Graduated | | | | | | |
| Other Co | llege Education | | | | | |
| Qualificat | ions or Experience | | | | | |
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| 1. Has the Director of Nursing ever been convicted of any criminal offense related to a dependent population? Yes No (If yes, state on a separate sheet the facts of each case completely and concisely) | | | | | | |
| | he Director of Nurse's License ever lapsed, or ever | | | ☐ Yes ☐ No | | |
| (If yes | s, state on a separate sheet the facts of each case c | | | | | |
| SECTON IV - DISCLOSURE OF OWNERSHIP AND CONTROLLING INTEREST STATEMENT (In compliance with the Indiana Health Facilities Rules (410 IAC 16.2) | | | | | | |
| A. Applicant Entity | | | | | | |
| Name of Applicant Entity (operator(s) of the facility) | | | | | | |
| D/B/A (Name of Facility) | | | | | | |
| | ership Information | | | | (50() | |
| List names and addresses of individuals or organizations having direct or indirect ownership interest of five percent (5%) or more in the applicant entity. Indirect ownership interest is interest in an entity that has an ownership interest in the applicant entity. Ownership in any entity higher in a pyramid than the applicant constitutes indirect ownership. (use additional sheet if necessary) | | | | | | |
| | Name | | Busines | ss Address | EIN Number | |
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| C. Type of Change of Ownership | | | | | | | |
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| ☐ Assignment of Interest ☐ | Lease | | Merger | | New Partners | ship | |
| ☐ Sale ☐ | Subleas | е 🗆 | Termination of Lease | | Other | | |
| D. Type of Entity | | | | | | | |
| For Profit | <u>No</u> | <u>onProfit</u> | | Go | vernment | | |
| □ torribut | | Observation Districts | | | 01-1- | | |
| ☐ Individual | | Church Related | | | State | | |
| ☐ * Partnership | | Individual | | | County | | |
| ☐ ** Corporation | | * Partnership | | Ц | City | | |
| *** Limited Liability Company | | ** Corporation | | | City/County | | |
| U Other (specify) | _ | *** Limited Liability | Company | Ш | Hospital District | | |
| | _ 🗆 | Other (specify) | | | Federal | | |
| | | | | | Other (specif | iy) | |
| *If a Limited Partnership, submit a copy of the "Applicati | ion For F | Registration" and "Cer | tificate of Registration" sign | gned | by the Indiana | Secretary of State. | |
| **If a Corporation, submit a copy of the "Articles of Incorporation" and "Certificate of Incorporation" signed by the Indiana Secretary of State. If a foreign Corporation, submit a copy of the "Certificate to do Business in the State of Indiana" signed by the Indiana Secretary of State. | | | | | | | |
| ***If a Limited Liability Company, submit a copy of the "Articles of Organization" and the "Certificate of Organization" signed by the Indiana Secretary of State. | | | | | | | |
| | N V - DI | SCLOSURE OF A | PPLICANT ENTITY | | | | |
| A. Officers/Directors/Members/Partners/Mana | | | | | | | |
| 1. List all individuals (persons) associated with the applicant entity and indicate the individual's title (i.e. officer, director, member, partner, etc). If the applicant is a partnership, list the name and title of each partner or the name and title of all individuals associated with each entity that forms the partnership. If the applicant is a Limited Liability Company, list the name and title for all individuals associated with each member entity that forms the Limited Liability Company. (use additional sheet if necessary) | | | | | | | |
| Name | | Title | Business A | ddre | ss | Telephone Number | |
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| 2. Are any individuals (persons) associated with the applicant entity (as listed in Sections IV.B and V.A.1) also associated with any other entity operating health facilities in Indiana or any other states? | | | | | | | |
| If "yes," list names and addresses of facilities owned | by each | individual. (use ad | ditional sheet if necessar | /) | | | |
| Facility Name | | Ade | dress | | City, County | , State, Zip Code | |
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| 3. | Is the licensee (applicant) a lease entity? \square Yes \square No | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|--|--|--|--|
| | If yes, explain | | | | | |
| | | | | | | |
| | Please submit a copy of the lease showing an effective date. If this is a sublease or assig Leases affected by this transaction. | nment of interest of a lease, submit a copy of all | | | | |
| | Is the applicant a subsidiary of another entity or corporation or does the applicant have subsidiaries u (If yes, list each entity (affiliated entity) on a separate sheet and explain the relationship) | ander its control? | | | | |
| | . Licensure/Operating History re any of the individuals (as listed in Sections IV.B. and V.A.1.), associated wi | th or hove they been eccesisted with one other | | | | |
| | ntity that is operating, or has operated, health facilities in Indiana or any other | | | | | |
| 1. | Has/had a record of operation of less than a full license (i.e. three month probationary, provi | isional, etc) | | | | |
| | Yes No (If "Yes", provide name of facility, state, date(s), restrictions and type) | | | | | |
| 2. | Had a facility's license revoked, suspended or denied. \Box Yes \Box No (If "Yes", prov | vide name of facility, state, type of actions and date(s)) | | | | |
| 3. | Was the subject of decertification, termination, or had a finding of patient abuse, mistreatme | - | | | | |
| | ☐ Yes ☐ No (If "Yes", provide name of facility, state, date, type of action, results of | action) | | | | |
| 4. | Had a survey finding of Substandard Quality of Care or Immediate Jeopardy deficiency reports, including the current or final resolution of the matter) | No (If "Yes", provide all correspondence and | | | | |
| 5. | Filed for bankruptcy, reorganization or receivership. Yes No (If "Yes", include all relevant documentation and provide a detailed summary of the events and circumstances. Include state, dates and names of facilities) | | | | | |
| NO | OTE: If any of the answers above are "Yes", list each facility on a separate sheet of paper | | | | | |
| 11- | SECTION VI - CERTIFICATION OF APPL | | | | | |
| I hereby certify that the operational policies of the health facility will not provide for discrimination based upon race, color. creed or national origin. | | | | | | |
| I swear or affirm that all statements made in this application and any attachments thereto are correct to the best of my knowledge and that the applicant entity will comply with all laws, rules and regulations governing the licensing of health facilities in Indiana. | | | | | | |
| Ар | oplicant's signature, as indicated in V-A of this application, or signature of applicant | 's agent should appear below. | | | | |
| IF SIGNED BY ANY INDIVIDUAL (EG., THE ADMINISTRATOR) OTHER THAN INDICATED IN SECTION V.A.1. OF THIS APPLICATION, AN AFFIDAVIT MUST BE SUBMITTED WITH THE APPLICATION AFFIRMING THAT SAID PERSON HAS BEEN GIVEN THE POWER TO BIND THE APPLICANT/LICENSEE. | | | | | | |
| Na | ame of Authorized Representative (Typed) | Title | | | | |
| Sig | gnature | Date | | | | |
| | | | | | | |
| ST | TATE OF COUNTY O | F | | | | |
| | | | | | | |
| Su | ubscribed and sworn to before me, a Notary Public, for | _County, State of, | | | | |
| this | isday of20 | | | | | |
| | | | | | | |
| | (SEAL) (Signature) | | | | | |
| | | , Notary Public | | | | |
| | (Type or Pr | int Name) | | | | |
| | My Commission expires | | | | | |